lorazepam for all patients to manage withdrawal symptoms. There was no documentation of risk profiling. We therefore recommended that tailored treatment based on patient profile be introduced. Risk profiling based on symptoms, signs and history and a symptom-triggered regimen for withdrawal management using nurse-administered CIWA-AR rating could be incorporated into a standard operating procedure (SOP). An SOP was developed and after team discussion and training it was introduced in October 2023.

Results. Re-audit of the implementation phase of SOP over three months (Oct 2023 to Dec 2023) was conducted. Case files were noted to document risk stratification as 34% low risk, 52% intermediate risk and 14% high risk. Symptom-triggered regimen was administered to all patients with added front-loading for all high-risk and some moderate-risk patients. Staff and patients expressed satisfaction with the new protocol. We noticed a significant reduction in the use of oral lorazepam (from 3324 mg for 63 patients during the comparative period of Oct 2022–Dec 2022 to 10 mg for 39 patients), while the use of injectable lorazepam increased by 25% (0.8 mg/patient to 1 mg/patient). Use of oral diazepam increased from nil to 170 mg with one patient receiving injectable diazepam.

Conclusion. Introducing an SOP that incorporated risk profiling, use of long-acting benzodiazepines, symptom-triggered and front-loading regimens and nurse-administered CIWA-Ar monitoring led to the reduced use of short-acting and uptake of long-acting oral benzodiazepines in inpatient alcohol withdrawal management. Decisions based on risk profiling led to an increase in the use of injectable benzodiazepines. We report that conducting this audit cycle led to the improvement of treatment standards in a specialized inpatient de-addiction centre in India.

7 Psychopharmacology

Association Between Prior Antipsychotic Adherence and Adherence Three Years After Clozapine Initiation: A Real-World Observational Study

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Aims. Our previous findings challenged the widely held view among a large proportion of psychiatrists (41% to 82%) that previous non-adherence to antipsychotics is a major barrier to the introduction of clozapine (Brodeur et al. 2022 BJPsych). Indeed, our previous work showed that most patients, even those with the poorest adherence profiles, remained on their treatment after clozapine initiation (>68% for clozapine and >84% for all antipsychotics combined) after one year of follow-up. Because of this, the study extended the follow-up period to three years to assess whether patterns of adherence were sustained over time. Therefore, this study aimed to determine whether poor adherence prior to initiating clozapine predicted poor adherence to clozapine or any other antipsychotic (including clozapine) three years after initiation.

Methods. This cohort study included 2,258 patients living in Quebec (Canada) with a diagnosis of SCZ who initiated oral clozapine between 2009 and 2016 (index date). Adherence to AP was measured by the medication possession ratio (MPR) over a 1-year period before and a 3-year period after the index date. Five groups of patients were formed based on their prior MPR level (independent variable), and two dependent variables were defined after clozapine initiation (good adherence (MPR $\geq$ 0.8) to any APs and to clozapine only). In addition to multiple logistic regression, state sequence analysis was used to visualise the trajectories of AP use over time, before and after clozapine initiation, for each group.

Results. The graphical representation of the SSA immediately showed that AP adherence was significantly improved in all groups, regardless of the level of previous adherence to AP treatment. On the other hand, logistic regression showed that poorer adherence to APs before the index date was significantly associated with an increased risk of poor adherence to any AP treatment 3 years after the index date (adjusted ORs ranging from 2.2 to 3.0). However, the majority of patients (ranging from 80.8% to 92.4%) had good adherence to any APs and to oral clozapine (ranging from 57.7% to 73.8%), regardless of previous adherence level.

Conclusion. These results add to previous findings and demonstrate that initiation of clozapine leads to improved adherence over a 3-year period. Although widely recognised by clinicians as a barrier to clozapine use, previous poor adherence does not appear to justify avoiding clozapine treatment in patients who would otherwise be considered eligible.

Abstracts were reviewed by the RCPsych Academic Faculty rather than by the standard *BJPsych Open* peer review process and should not be quoted as peer-reviewed by *BJPsych Open* in any subsequent publication.

Accepted posters

Arranged by the presentation category selected by the submitter and by order of presenting author surname.

1 Research

Pilot Study Examining the Potential Efficacy of Music-Based Activities for People Living With Dementia in a Hospital Setting

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Aims. Pharmacological treatment of Behavioural and Psychological Symptoms of Dementia (BPSD) is of limited

benefit. The addition of non-pharmacological interventions is often essential for optimal symptom control. Music is a viable way to help patients communicate and improve quality of life. This study aims to find the most effective way to use music on a busy dementia ward.

Methods. 17 inpatients (aged 63–93 years) took part over a five-week period. Music with projected lyrics was individualised and based on their preferences. Instruments (e.g., maracas) were used in some group sessions. We used the Neuropsychiatric Inventory Questionnaire (NPI-Q) and Music in Dementia Assessment Scales (MiDAS) to evaluate patients' behaviour before and after musical intervention.

Results. Of NPI-Q scores, a significant difference between mean scores before and after the music intervention was found. Specifically, Delusion, Motor Disturbances, and Agitation scores were significantly reduced after music intervention. Of MiDAS, significant differences were found in Interest, Response, and Enjoyment during specific intervals.

Conclusion. A multisensory inpatient environment was effective in delivering music-based activities and managed behavioural symptoms in the short term to people with advanced dementia. Its use for inpatient wards must be further investigated as an economical and personalised non-pharmacological therapeutic tool for patients with dementia.

The Emotional Experiences of Women Suffering From Premenstrual Dysphoric Disorder in the United Kingdom

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Aims.

1) To hear directly from women suffering from PMDD about their lived experiences of PMDD and the impacts that it has on their daily lives.
2) To raise awareness about the impacts that PMDD can have on patients' quality of life, relationships, and productivity, to improve clinicians' understanding of patients' needs.
3) To identify a gap in research into PMDD within the UK and highlight the need for further research.
4) To improve awareness of PMDD amongst diverse stakeholders, including women who are not yet diagnosed with PMDD, employers, and policymakers.

Methods. Participants were recruited from the UK's PMDD Patient Insight Group and screened using the Premenstrual Symptom Screening Tool (PSST) for PMDD. Eligible participants were purposively sampled, and 15 participants were invited to a semi-structured scheduled interview on Zoom. Interviews were transcribed using NVivo transcription software, and inductively analyzed using reflexive thematic analysis in NVivo 14.

Results. Thirteen subthemes were identified and organised around four main themes: Theme 1: 'Jekyll and Hyde', Life with PMDD, Theme 2: 'The Aftermath', The Impact of Living with PMDD, Theme 3: 'Surviving PMDD', Coping Strategies, and Theme 4: 'Seeking Treatment', Experiences with Healthcare. The themes identified in this study highlight the negative experiences of women living with debilitating symptoms that appear during the luteal phase and disappear following the onset of menstruation. Themes also capture the immense burden PMDD places on a sufferer by uncovering how exactly these symptoms affect interpersonal relationships, career progression, quality of education received, and relationship with oneself. Theme 4 focuses on women's negative experiences with healthcare stemming from a lack of awareness of PMDD in the medical community.

Conclusion. The findings of this study highlight the critical importance of understanding the contextualized experiences of women living with PMDD in the UK and bringing to light the immense monthly burden sufferers face. To prevent women and Assigned Female At Birth (AFAB) individuals from experiencing severe and prolonged psychological distress which can have fatal consequences, there needs to be greater understanding and awareness of PMDD in both medical and lay communities. In addition to this, clinicians must be trained in PMDD assessment and research should be encouraged to introduce new treatments and to implement policies that minimize the burden of PMDD in the workplace.

How Are FOMO and Nomophobia Linked to Symptoms of Depression, Anxiety and Stress Among University Students?

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Aims. Nomophobia, defined as the fear of being without one's mobile phone, and FOMO (Fear of Missing Out) are on the rise and are thought to be linked to increased mental health problems. In the information era, being separated from smartphones may cause anxiety, while the expectation of continuous updates on social media may increase feelings of inadequacy and distress when comparing one's life with selected highlights of others. The extent of nomophobia and FOMO in the Middle East and whether these experiences are associated with psychiatric disorders are yet to be ascertained. The purpose of this study was to determine the prevalence of nomophobia and FOMO among university students in the UAE and the relationship between these phenomena and depression, anxiety and stress levels.

Methods. 232 female and 103 male undergraduate students in four Emirates (Abu Dhabi, Dubai, Sharjah, and Ajman) took part in the study. An online questionnaire was developed and piloted. Nomophobia and FOMO were measured using validated questionnaires, namely NMP-Q and FoMOs. Symptoms of depression, anxiety and stress were assessed using the DASS-21 scale. Data were analysed using SPSS 22. Significance level was set at $p < 0.05$.

Results. The data revealed that 28.6% of respondents exhibited severe, 47.7% moderate, and 23.7% mild nomophobia symptoms. 52.5% of participants reported moderate to extreme fear that others have more rewarding experiences than them, with the median FoMO score being (25.62). Higher nomophobia, stress,